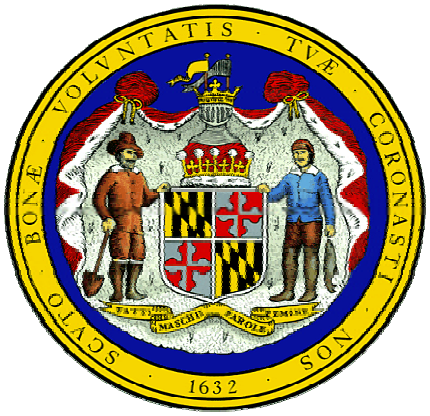
An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Working Paper: Inpatient Psychiatric Services

Analysis of Public Comments and Staff Recommendation



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Summary and Analysis of Public Comments and Staff Recommendations

An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Inpatient Psychiatric Services

I. Introduction

The working paper entitled *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Inpatient Psychiatric Services* was developed by staff to the Maryland Health Care Commission as one in a series of working papers examining major policy issues of the Certificate of Need process, as required by House Bill 995 (1999). The paper provided background on the utilization of and reimbursement for these services in the three distinct settings in which inpatient psychiatric care is given – acute general hospitals, private psychiatric hospitals, and State hospital centers – and described the kinds of government oversight brought to bear on inpatient psychiatric services in Maryland. Staff outlined six options representing potential alternative regulation strategies for the Commission's consideration. They included:

Option 1: Maintain Existing Certificate of Need Program Regulation

Option 2: Expand Certificate of Need Program Regulation

Option 3: Deregulate Creation of Additional Levels of Inpatient Psychiatric Services from Certificate of Need Review

Option 4: Deregulate Inpatient Psychiatric Services from Certificate of Need Review; Create Data Reporting Model

Option 5: Deregulate Mental Hygiene Administration Hospitals from Certificate of Need Review

Option 6: Deregulate Inpatient Psychiatric Services from Certificate of Need Review

The working paper was released for public comment at the MHCC's October 25, 2000 meeting. A total of ten organizations submitted written comments to the information and alternative regulatory options presented; these comments are summarized in Part II of this paper. Staff provides its analysis of the public comments in Part III, and Part IV presents Staff's proposal for the Commission's recommendation to the General Assembly on whether to continue to regulate inpatient psychiatric services in Maryland through Certificate of Need. **Public comment on this document, and on Staff's proposed recommendation, is due to the Commission by October 5, 2001.**

The organizations providing public comment included the trade association with responsibility for both the State's acute general hospitals and its private psychiatric hospitals, as well as a county Board of Health; three of the four private psychiatric hospitals provided comments, representing a third of the organizations represented. Of the hospitals and hospital systems commenting on the Working Paper and its regulatory alternatives, one was a stand-alone community hospital, and two were metropolitan hospital systems providing significant levels of inpatient psychiatric care. Of the State's two major university-affiliated hospital systems, Johns Hopkins was represented in this round of responses by the clinical director of the Hospital's psychiatry department. The Health Services Cost Review Commission, a key factor in the operation and the future of inpatient psychiatric care as the rate-setting authority for both acute general and private psychiatric hospitals, submitted comments by Executive Director Robert Murray. In summary, the commenting entities were:

- The Association of Maryland Hospitals and Health Systems (MHA)
- Howard County Board of Health
- Adventist HealthCare
- Sheppard Pratt Health System
- Taylor Health System
- Carroll County General Hospital
- LifeBridge Health
- MedStar Health
- The Department of Psychiatry and Behavioral Health, Johns Hopkins University and Hospital
- Health Services Cost Review Commission

The comments submitted on this Working Paper were noteworthy in their common recognition that Certificate of Need regulation of entry into this arena and of bed capacity at individual units or facilities is far from the most pressing issue or challenge facing providers of inpatient psychiatric services. More than for any medical service examined thus far in the Commission's legislatively-mandated study of Maryland's CON program, the professionals and institutions most involved in mental health services focused on the problems related to reimbursement methods and levels, as the obstacle that compromises access to inpatient psychiatric care.

II. Summary of Public Comments

In its response to the Commission's working paper on inpatient psychiatric services, the **Association of Maryland Hospitals and Health Systems (MHA)** noted that its Council on Legislative and Regulatory Policy reviewed the document and its alternative regulatory options, and recommended that the State continue to regulate inpatient psychiatric services through Certificate of Need review. MHA's policy council saw "nothing in the regulatory environment or clinical setting" to warrant a departure from CON regulation of this service; to date, MHA's recommendations on hospital-based services have favored retaining CON as the Commission's primary tool for

assuring that new bed capacity or services are needed and financially supportable.[1] MHA's comments also called the new prospective payment system being developed for private psychiatric hospitals[2] "a very positive step toward meeting the mental health needs of the state's poor," and suggested that the Commission consider evaluating the effect of the new reimbursement system as it comes on line, to gauge its impact on delivery of and access to inpatient psychiatric services.

The **Howard County Board of Health** supports both Option 3, which would remove from the State Health Plan the requirement to obtain a separate Certificate of Need for each level of inpatient psychiatric service (i.e., child, adolescent, or adult), and Option 4, which would deregulate inpatient psychiatric services from CON review, in favor of an enhanced data collection requirement, and the publication of "report cards . . . to encourage continuous quality improvement."

As noted above, three of the State's four private psychiatric hospitals submitted detailed comments in response to the Working Paper.[3] **Adventist HealthCare** acquired the Potomac Ridge Treatment Center in Rockville in September 2000; its comments were submitted by Craig S. Yuengling, who continued to serve as the facility's chief administrator after the Adventist acquisition, becoming president of Potomac Ridge Behavioral Health and a regional vice president for Adventist Health Care's behavioral health operations.[4] Adventist Health Care supports Certificate of Need for this service as "necessary to assure an appropriate distribution of inpatient beds," but does not support the creation of additional bed capacity through the CON exemption process. Increasing bed capacity in this way would, Adventist believes, "result in further instability for the already fragile private psychiatric facilities," and the additional competition "would result in the need to increase HSCRC charges" in response to a resulting decrease in patient days at existing facilities.

Adventist Health Care and Potomac Ridge believe that no additional regulatory authority – such as that proposed by Option 2 of the Working Paper, to require Commission action through CON exemption on all proposed facility or unit closures – is

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[1] It is important to note that MHA's comments do not restrict the right of its members to comment on their own behalf, which many have done with regard to each of the Working Papers released in the CON study.

[2] The development of this system was discussed in the Working Paper at pages 19-20. The federal Center for Medicare and Medicaid Services (formerly the Health Care Financing Administration) gave verbal approval on July 17, 2001 to the plan to establish a PPS for Maryland's private psychiatric hospitals that would apply to medical Assistance recipients as well as those with private insurance; its effective date will be July 1, 2001. With technical assistance from HSCRC, the Mental Hygiene Administration and the Medicaid program are now engaged in implementing the new system.

[3] Brooklane Health Services in Washington County did not submit written comments at this stage of the examination of CON for inpatient psychiatry services. CPC Health operated 110 adult psychiatry beds at Chestnut Lodge Hospital until its bankruptcy proceeding in late winter 2001; this bed capacity was acquired by Sheppard Pratt Health System, which has until April 27, 2002 to develop the bed capacity elsewhere in Montgomery County.

[4] Potomac Ridge's comments presented corrected data for the facility's 1998 through 2000 inpatient beds, since the HSCRC data presented in the Working Paper combined hospital data with data from the facility's residential treatment center. The corrections will be made in the final version of the inpatient psychiatric services section in the "Phase 2 Final Report" due to the General Assembly in January 2002.

needed with regard to closing inpatient psychiatric services. Adventist/Potomac Ridge suggests that requiring a public hearing prior to the closure of a financially failing hospital would exacerbate an already dire situation, and believes that the authority of the Department's Office of Health Care Quality to oversee the timely and appropriate placement of patients in alternative settings sufficiently protects the public.[5]

Adventist/Potomac Ridge approves of the flexibility that Option 3 of the Working Paper would give providers, to expand an existing program with additional levels of inpatient psychiatric service without a separate CON approval for each, but "strongly agrees" with the Working Paper's stipulation that facilities proposing this expansion should be required to have separate programs and physical space for children, adolescents, and adults, as well as Board-certified psychiatrists and other staff specializing in children's, and presumably also adolescent, psychiatric services.

Adventist/Potomac Ridge believes that requiring providers to report information to the Office of Health Care Quality is appropriate, as long as the data collection parallels (and is not more "burdensome or costly" than) the ORYX system used by the Joint Commission on the Accreditation of Healthcare Organizations. Consumer report cards, however, while they may seem an "excellent idea" conceptually, Adventist/Potomac Ridge believes to be problematic, and potentially misleading for a person who does not thoroughly understand the nature of behavioral health and "the difference in patient populations between providers."

With regard to Option 5, which proposes to remove the CON requirement to establish new State psychiatric facilities, Adventist/Potomac Ridge asserts that CON regulation of new State hospital capacity is not the significant issue: "the budget allocated to operate sufficient capacity [at State facilities] is much more important." Numerous problems besetting the entire system of mental health care – increased burdens on are emergency rooms, "seasonal and cyclical bed shortages in acute and private inpatient facilities" -- are attributed by the Adventist system and its Potomac Ridge facility to the steady decline in the number of beds operated at State facilities. The State is urged to "commit sufficient funding" to serve the "vulnerable population" – the poor, the chronically mentally ill – who presumably are its particular responsibility.

The comments submitted by Steven S. Sharfstein, M.D., President and CEO of the **Sheppard Pratt Health System**, focus initially on the reimbursement issues that have presented a unique set of challenges to the private psychiatric hospitals. These facilities, because of the current retrospective system of settling Medicaid accounts, have been owed "substantial sums of money . . . for periods of five to six years while awaiting

[5] The Adventist comments cite the recent closure of CPC/Chestnut Lodge as example, to support its contention that the licensing agency's oversight is sufficient to guarantee an "orderly transition of patients" during an impending closure. In fact, current statute requires any hospital intending to close to hold a public hearing within thirty days of its written notice to the Commission. The CPC closure took place in the context of an extended bankruptcy proceeding, and an (ultimately unsuccessful) effort over several months to find a buyer willing to continue providing the extensive inpatient and outpatient services on the existing campus in Rockville. Because the bed capacity was acquired by Sheppard Pratt, no hearing was required before the closure.

settlements of cost reports," with no allowance for interest on this money, or for the costs the private hospitals have incurred to stem cash flow shortfalls. The private hospitals are looking to the State's implementation of the new prospective payment system, now approved in concept by CMS/HCFA, to remedy an extremely difficult financial situation.

Contributing to the difficulty of the financial situation it faces, Sheppard Pratt also observes that – "because private psychiatric hospitals are not in the HSCRC all payor system and because Medicare and Medicaid have paid us their definition of reasonable cost" -- only about 40% of the care private hospitals deliver is paid for according to these HSCRC's average charges. Consequently, the average cost per admission, paid for "nearly two-thirds of [Sheppard Pratt's] admissions" is considerably less than the charge-based figures provided in the table included on page 19 of the Working Paper.

Sheppard Pratt's comments also note, with regard to the Working Paper's discussion of "State hospital capacity and the conflict between their continued strong utilization and a mandate to continue downsizing efforts," that it has repeatedly offered to creat a "diversion unit to absorb a portion of those 14% direct 'acute' admissions to the State system" through a purchase of care contractual arrangement, so as to allow State hospitals to "focus on the intermediate and long term populations." Dr. Sharfstein urges the Commission to encourage this development of partnerships between the State and "cooperative partners with identified capacity" to more efficiently address the need for inpatient psychiatric services.

Responding to the six options for the future direction of CON regulation presented in the Working Paper, Sheppard Pratt "explicitly favor[s] the continuation of CON requirements for establishing additional inpatient psychiatric capacity," the paper's Option 1. With regard to Option 2, extending to requirement for Commission action through a CON exemption for all closures of psychiatric units or facilities – in effect, re-imposing this requirement, removed in 1999 by HB 994, on both State hospitals and those in counties with three or more hospitals – Sheppard Pratt observes that requiring Commission action would not deter a truly "distressed" private provider from closing. However, it would not consider re-imposing this requirement as "negative" if it serves to "focus attention on the economic and public policy issues" that underlie this kind of "business decision."

Sheppard Pratt does not support removing the present State Health Plan's requirement for separate CON approvals for each age-related level of inpatient psychiatric service (Option 3), and questions whether the existing allocation and operation of the different service levels actually conforms to this Plan policy directive. It cites the fact that "general acute adult psychiatric units . . . admit patients in the 14 to 18 age spectrum" as the basis for the question.[6]

[6] Hospital discharge data do in fact show instances where general hospital adult units admit patients aged 14 through 18. Staff will present an analysis of this data and administrative practice in the upcoming working paper on child and adolescent inpatient psychiatric services and residential treatment centers.

In considering Option 4, Sheppard Pratt does not view the creation of either a provider- or consumer-focused "report card" based on an enhanced system of data collection as "an alternative to a needs based assessment" like CON review, and does not believe that an adequate set of performance measures exists to establish such a system. However, Sheppard Pratt explicitly supports broad access to "accurate, current data," and implicitly supports a State Health Plan with policies and review standards that respond as quickly as possible to current clinical, administrative, and fiscal realities.

Although Sheppard Pratt believes that Option 5's proposal to remove the CON requirement for a new State psychiatric hospital is "reasonable, since the destiny of state hospital services is driven by other forces within the government," it also believes that some level of public process is still needed, as a forum in which even the State's decisions to enter or exit this "market" are discussed, and both provider and consumer communities may be heard and considered.

With regard to Option 6, the deregulation of inpatient psychiatric services from Certificate of Need review, Sheppard Pratt's comments are unequivocal. To deregulate these services from the Commission's oversight through CON review "would have a very destabilizing effect on the availability and viability of psychiatric services," and the System urges that the Commission not recommend their deregulation.

As was the case for both Adventist/Potomac Ridge Behavioral Health and Sheppard Pratt, issues related to reimbursement for services are an important focus in the comments by Bruce Taylor, M.D., Medical Director of **Taylor Manor Hospital**. Indeed, Dr. Taylor's letter begins with his institution's support for Option 1, maintaining the existing Certificate of Need regulation of inpatient psychiatric services, and immediately moves beyond the scope of the Working Paper and of CON itself, to address the whole spectrum of issues faced by private psychiatric hospitals in Maryland.

Summarized briefly, Taylor Manor Hospital's comments note that CMS has approved in concept the new prospective payment system for Medical Assistance recipients, which will bring both Medicaid and private insurance under HSCRC's rate regulation. While the private psychiatric hospitals are "grateful for this relief," only by bringing the Medicaid rates up to 94% of the rate level set for privately-insured patients, a substantial increase from the 80% of commercial rates at which they will initially be set, can the new system work "appropriately and fairly" to pay the hospitals adequately, and "maintain the broadest access possible for the citizens of Maryland." Further, Taylor Manor strongly advocates bringing the private psychiatric hospitals into Maryland Medicare Waiver, so that both Medicare and Medicaid must pay 94% of the current HSCRC rates charged by the private hospitals – a step steadfastly opposed by HSCRC, as discussed below. Unless the private hospitals are brought into the Waiver, Taylor Manor is very unlikely to resume accepting Medicare patients, whose admission it suspended in November 2000.

However, although Dr. Taylor wants his and other private hospitals brought into the Medicare Waiver with the State's acute general hospitals, he wants them excluded

from the HSCRC's charge-per-case ("CPC") system, so that they may "continue to serve as a 'safety valve' for the health system." In other words, Taylor Manor believes that the State must create a reimbursement framework that enables the private psychiatric hospitals to continue in their historic role as the placement of choice for general hospitals with patients needing a longer stay than is "in [the hospitals'] best interest" (because of the impact that longer stays will have on CPC performance), and also as an alternative to placing further burdens on State facilities. The interconnectedness of the three settings of inpatient psychiatric services in Maryland -- the reverberations that problems in one sector can cause in the other two – at least argues that a comprehensive and consistent approach to reimbursement policies is necessary.

Taylor Manor also advocates in its comments for adequate funding in all levels of the mental health system, including for the community placements (particularly residential treatment center beds for children and adolescents, of which Taylor asserts there is a "continuing shortage") needed to move patients out of inpatient beds and into less restrictive levels of care. Its comments also go beyond mental health services, to note the "significant psychiatric and public health problem" of those with substance abuse disorders, who are "under-served, under-treated, and under-funded throughout the entire State at all levels of care and for all segments of the population," regardless of payer source.

Taylor Manor's comments return briefly to the subject of CON regulation of inpatient psychiatric services, with its view that HB 994 does not distinguish between acute general and private psychiatric hospitals in its merger or closure provisions.[7] Taylor Manor also notes that, while it "has agreed to reduce its licensed capacity [from 204 licensed beds] to 92 beds in accordance with its most recent rate increase" granted by HSCRC, it has the physical capacity to again increase its bed capacity, once reimbursement systems improve, and "private psychiatric hospitals eventually come under the Federal Medicare Waiver."[8]

While the specifics of their settings and situations may differ, the acute general hospitals with inpatient psychiatric services express the same basic concerns – about the interrelated nature of the three settings in which these services are provided and the impact of any change or crisis in one setting on the others, as well as the availability and level of reimbursement for those services. Three sets of comments addressing the Working Paper came from community hospitals providing inpatient psychiatric services: one from Carroll County General Hospital, a stand-alone sole county provider, and two from merged asset hospital systems serving metropolitan areas, LifeBridge Health (which includes Sinai and Northwest Hospitals) and MedStar Health (whose Maryland hospitals include Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital.

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[7] There are significant provisions in HB 994 whose different application to the various statutory categories of hospital is clear, and has been further interpreted in Commission regulation; see Part III for a discussion of this issue.

[8] Taylor Manor has not provided the notice to this Commission required by COMAR 10.24.01.03C *et seq*, and is subject to the conditions and time limitations for delicensing previously operating bed capacity established by that regulation, which took effect on February 5, 2001.

Comments submitted on behalf of **Carroll County General Hospital (CCGH)** by its CEO John M. Sernulka begin – as did most of those responding to the Working Paper -- by observing that "the issues facing inpatient psychiatric services in Maryland go far beyond the CON law." Providers of this service across all settings are challenged by an interacting set of circumstances: legislative budget decisions determine the level of both hospital and community-based services that will be funded by the State; the courts and other State entities make involuntary commitments for which resources must be identified; and all inpatient facilities must struggle to find qualified professional staff during a time of critical shortages. All of these problems are intensified by the increasingly restrictive reimbursement policies of both public and private payers, and by the number of those with mental health care needs with no insurance at all.

Mr. Sernulka's letter states unequivocally that "the complex problems facing inpatient psychiatric services in Maryland . . . are interrelated and can only be effectively resolved through a comprehensive public process including all of the state, public and private entities" with a stake in – and responsibility for – solving them. Understanding that real, lasting solutions to the problems it identifies go well beyond the authority and responsibility of the CON program, and will require "a comprehensive analysis and review that includes all of the governmental and private entities involved," CCGH raises the following issues:

CCGH notes that the Certificate of Need it received from the former Health Resources Planning Commission in April 1988 designated only 8 of its psychiatric beds as adult beds, with 12 designated for adolescents,[9] while the Working Paper at Table 2 on page 4 identified all 20 of the CCGH beds as dedicated to adults. Staff used as its source for the number of beds dedicated to child, adolescent, and adult psychiatric care each hospital's self-reported breakdown of categories represented, submitted to the Commission for the current year's Bed Licensure calculation and inventory. CCGH identified all 20 of its beds as adult beds in these documents.

CCGH maintains that the aggregate list of psychiatric bed capacity in all settings presented in Table 1 of the Paper does not present a true picture of available, staffed bed capacity in this service. This is true, since the intent of that table was to show the total available bed capacity in the system; other tables further on in the document distinguish licensed capacity from beds that are actually staffed and operating. Table 6 presents the total licensed bed capacity at the eight State hospital centers, as well as the number of staffed, operating beds. The Mental Hygiene Administration reported that only 1,349 of its statewide total licensed bed capacity were staffed and operating in the year 2000, or

[9] The HSCRC Hospital Discharge Database for fiscal years 1996-2000 shows that although CON-approved for 12 adolescent and 8 adult beds (a 3:2 ratio), CCGH's discharges for the last three years have been inconsistent with that designation: in FY 2000, for example, 127 of CCGH's discharges were 13-17 years old (6 were under 12, and therefore should only be admitted to child-dedicated beds), while 666 discharges were 18 years of age or above—approximately a 1:5 ratio of adolescents to adult discharges. As previously noted, Staff will present an analysis of the designation of categories of inpatient psychiatric beds as compared to their actual utilization experience, as part of its upcoming Working Paper on Child and Adolescent Psychiatric Services.

slightly more than 61% of the total. Staff did not solicit the licensed versus staffed and operating bed totals from the acute general or the private psychiatric hospitals, but assumed that at least the acute general hospital totals – given the yearly opportunity to designate the size of these units presented by the recalculation of bed capacity according to the HB 994 formula, 140% of the previous year's average daily census – reflected the number of beds each hospital expects to be able to staff and operate. With regard to the private hospitals' "real" capacity, Taylor Manor's experience may be instructive: it has agreed to reduce its licensed capacity from 204 to 92, as part of its current rate agreement with HSCRC, as a reflection of hard fiscal and clinical realities.

CCGH also observes that the Working Paper does not address the issue of "proxy bed" agreements with the Mental Hygiene Administration. This program, under which acute general or private hospitals execute contracts with the Mental Hygiene Administration to serve as a "proxy" for State beds, extends the State's ability to care for under- and uninsured patients. CCGH participates in this program, but cites several problem that the Department needs to address, including low reimbursement levels and delays in receiving payment, and the availability of community-based services for proxy bed patients after discharge.

The CCGH comments also note that maintaining a "locked unit," and accepting forensic admissions from the courts and other governmental agencies, causes unique problems for the hospitals affected. The designation of an acute general hospital as one that accepts petitions for emergency evaluations and involuntary committals – that maintains a "locked unit" – can cause some significant problems for facilities. As CCGH's letter observes, these patients are typically "hard to place, require the highest level of care, and yet involve the longest waiting periods to receive care," because of the frequent inability of emergency departments to locate an appropriate admission placement. As a result, these patients often must remain for 12 to 24 hours in the ED, where they require intensive supervision, get little or no actual treatment, and divert staff and physical resources from other patients. Forensic admissions, dictated by the courts and other State agencies, similarly divert bed capacity and other resources from other patients, present "safety and welfare issues," and have a negative effect on the general hospital's length of stay and other rate-sensitive variables. This is another issue that CCGH believes "cuts across several regulatory and legal frameworks," and demands a cooperative approach to a solution.

CCGH believes that the success of any State effort to de-institutionalize the chronically mentally ill will depend primarily upon the availability of sufficient community-based services. If the State's plan to move all but the most seriously and persistently mentally ill out of its hospitals is to succeed in the long run – from the patient's as well as from the government's perspective – then "adequate and accessible alternative community services" must be waiting for those discharged. CCGH questions whether a comprehensive plan exists to develop and support the necessary resources, and

whether the "master plan" for de-institutionalization will realize the cost savings intended to finance these efforts.[10]

CCGH concludes its comments with the concern over "the ability of acute general hospitals in jurisdictions with three or more hospitals to close their inpatient psychiatric services with only 45 days notice to the Commission," a provision of 1999's HB 994 discussed at length in the Working Paper. The closure of an inpatient psychiatric service in a neighboring county's hospital (or of the 602-bed Springfield Hospital Center in southern Carroll County, which this provision also explicitly permits) could seriously compromise the ability of CCGH to meet its community's needs. Accordingly, CCGH supports Option 2, which proposes a statutory change to again require all hospital or service closures to obtain Commission action, by exemption from CON review, not only those in counties with one or two hospitals as under present law.

LifeBridge Health submitted comments on the Working Paper on behalf of its acute general hospital members Sinai Hospital of Baltimore, which operates 24 adult psychiatric beds, and Northwest Hospital Center, which opened its CON-exempt 12-bed adult unit on August 1, 2001, and Levindale Hebrew Geriatric Center and Hospital, which operates a 12-bed chronic hospital psychiatric unit.

LifeBridge Health supports the "continued Certificate of Need regulation of new acute inpatient adult psychiatry beds," as a means of preserving both geographic and financial access to this level of psychiatric care throughout Maryland, through the identification of unmet need in the State Health Plan and the encouragement of new programs in underserved areas. LifeBridge believes from its own experience that the State's most critical needs are for more inpatient beds dedicated to care of children and adolescents, and for beds (and presumably, resources) to care for patients in need of far longer stays than the 6.69 days identified by the HSCRC hospital discharge data as the statewide average length of stay in the year 2000. For these two categories of patients, placement is often very difficult, since both child and adolescent beds and "chronic" psychiatric beds are "not widely available in the State"; when these patients come to the emergency departments at Sinai or Northwest Hospitals, they are often sent to specialized care units at private psychiatric facilities or to a State hospital.

For this reason, LifeBridge supports any administrative flexibility that can encourage existing providers to devote beds, or to establish services, to care for both children and adolescents and the chronically mentally ill. The proposal presented in the Working Paper as Option 3, which would remove the separate CON requirement for an existing provider of inpatient psychiatric services, receives LifeBridge's support as a way "to facilitate much-needed child and adolescent beds in the community." The Working

[10] While the Commission has no Certificate of Need authority over psychiatric services provided in outpatient or other community-based settings, their availability and viability has a direct bearing on the need for inpatient capacity, and will be carefully considered as Staff updates the State Health Plan for psychiatric services in the coming months. Staff expects to work closely with staff of the Mental Hygiene Administration to analyze the utilization patterns of the Public Mental Health System by Medicaid and gray area patients, and the impact of the "carve-out" of mental health services from the HealthChoice program and its separate administration by contractual entity.

Paper described a review process for this kind of expansion into an additional category of inpatient psychiatric service, which would require the development of new State Health plan standards specifying the requirements -- of staff, clinical program, and physical space -- that the facility would have to meet in order to receive Commission approval. LifeBridge believes that a determination of non-coverage by CON, reached after staff review of expansion proposals according to these new standards, would be a sufficient level of oversight, which would permit existing providers of inpatient psychiatric services to "use the expertise and support structure already in place" to provide another, needed level of care.

LifeBridge Health also supports the increased oversight of closures of hospitals and medical services embodied in the Working Paper's Option 2, arguing that the very interdependence of the three settings of inpatient psychiatric services in Maryland requires that the same level of regulatory review apply to all proposed closures. Acute general hospitals depend upon the availability of beds at both private and State psychiatric hospitals, for the placement of emergency room patients as well as patients who need a longer course of inpatient treatment than general community hospitals provide. Consequently, LifeBridge believes that any proposal to close an existing psychiatric hospital or unit -- whether a State facility, a private hospital, or an acute hospital in a jurisdiction with three or more hospitals -- should be required to obtain an exemption from CON. This level of scrutiny and analysis, required in current law only in jurisdictions with one or two hospitals, would consider "the potential impact on patients and their continued access to care."[11] LifeBridge also supports requiring Commission action through CON exemption for "any proposal to close an inpatient child or adolescent psychiatry service at an acute care hospital."

MedStar Health submitted comments by John L. Green, Executive Vice President for Corporate Services, on behalf of its Maryland hospitals in metropolitan Baltimore, including Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital, as well as its District of Columbia members, Georgetown University Hospital, National Rehabilitation Hospital, and Washington Hospital Center. Referring to its overall position statement issued in November 1999, MedStar reiterated its support for the "the current CON mode of regulation . . . because we believe this process protects patients' access to high quality, cost-effective services," primarily by ensuring that the development of health care services is "consistent with state health goals and policies."

Specifically, with regard to the CON regulation of inpatient psychiatric services, MedStar supports Option 1, which maintains the existing CON program. MedStar notes that "free market" control of the supply of beds and services has resulted in "unprecedented growth" and a geographic redistribution of beds and programs away from some underserved areas of states like Pennsylvania and Ohio, where all or some formerly CON-regulated services have been deregulated. MedStar believes strongly that "there is

[11] See the discussion in Part III concerning the ambiguity of current statute with regard to the applicability of the provisions governing closure with 45-day notice to "special hospital"-licensed facilities such as private psychiatric hospitals.

a compelling State interest in controlling the potential oversupply and duplication of costly facility-based services, and in ensuring the geographic, financial, and cultural accessibility of these services."

MedStar emphasizes in its comments that CON procedural regulations "should apply equally to all inpatient psychiatric services, whether they are located in acute hospitals, freestanding private hospitals or state-operated facilities." MedStar specifically does not support Option 5, the elimination of all CON requirements for State facilities, because – with most of the commenting institutions – it believes that "policies affecting any one of [the three] distinct settings" in which psychiatric inpatient services are delivered "have repercussions in the other settings." Certificate of Need oversight, MedStar believes, should consider need and capacity issues "in the context of all available and appropriate settings of care," and seek a balance among them.

MedStar notes that current law permits the reconfiguration of beds between members of a merged asset hospital system. In fact, Commission statute has permitted increases and decreases in beds in merged systems, through a CON exemption action by the Commission, since 1985. In 1999, however, HB 994 permitted such changes in bed capacity between system members, under certain conditions set forth at Health-General §19-123(i), to be undertaken with only a 45-day written notice to the Commission, but stipulated that, *using the subsection's mechanism of 45-day notice*, a merged system could not create a new service by moving beds across jurisdiction boundaries.[12] Continuing this discussion, MedStar warns that "giving merged asset systems the ability to relocate psychiatric services across jurisdictions would set a dangerous precedent," and result in "dramatic redistribution of beds with minimum public input."

Regarding the "particular problem" of closures of inpatient psychiatric facilities and units, MedStar notes that inadequate reimbursement has recently resulted in closures of private hospitals – but argues that the answer is "not to further regulate closures, but to improve reimbursement" so that providers "can afford to stay in business." MedStar notes that with the 1999 provision permitting acute general hospitals in jurisdictions with three or more hospitals to close (or to close a medical service) after a 45-day notice to the Commission, came the requirement that the hospital hold a public hearing and make "adequate provision . . . for the patients who received services at that facility."[13] MedStar believes that "the existing CON regulations provide sufficient oversight [of the public interest issues involved in proposed closures of inpatient psychiatric services], when they are applied equally to all inpatient psychiatric settings, whether . . . in acute hospitals, freestanding private hospitals on in state-operated facilities." From this statement, it is unclear to Staff whether MedStar advocates extending the requirement for Commission action through CON exemption – applicable to facilities in jurisdictions with one or two hospitals – to all hospitals with inpatient psychiatric beds (Option 2 of the Working

[12] Reconfiguring existing medical services among merged asset system members is permitted under a different subsection of CON law, the "change in type of scope of services" provisions at §19-123(j), but requires Commission action through CON exemption.

[13] Although MedStar's comments imply that the same requirement does not apply to State hospitals intending to close, statute at §19-123(l)(1) makes no distinction between the two types of hospital with regard to the administrative actions required before closure.

Paper), or, alternatively, permitting any hospital with inpatient psychiatry to close after only a 45-day notice and a public hearing, regardless of setting or status.

MedStar in its comments also supports the proposal in Option 3, "given the current shortage of child and adolescent beds," to afford procedural incentives to existing Providers who seek to add one or more new categories of inpatient psychiatric service, through the reallocation of existing beds or, particularly, through the creation of new beds and services for children and adolescents. An "exemption process" could accomplish this goal, by requiring compliance with quality-oriented standards related to staffing, program, and physical space tailored to the clinical needs of the proposed new population(s).

The perspective of the physicians and other clinicians practicing in one of Maryland's two university-affiliated teaching hospitals was represented by comments submitted by **Michael J. Kaminsky, M.D., Clinical Director of the Johns Hopkins Hospital Department of Psychiatry and Behavioral Health.**[14] Johns Hopkins Hospital's inpatient psychiatry service, with a total of 103 beds, is the largest among Maryland's acute general hospitals.[15] Dr. Kaminsky and his department implicitly support the continuation of Certificate of Need regulation for inpatient psychiatry services in the State, since they advocate the Commission's adoption of Options 2 and 3. These proposals would, respectively, re-impose the requirement to obtain Commission action though CON exemption on all proposed closures of psychiatry units of facilities, and remove the present requirement that an existing program obtain a separate CON for each additional category of inpatient psychiatric care. However, these comments – a first, forceful response from the State's academic medical community to the issues raised in the Commission's study of Certificate of Need -- also go far beyond the scope and authority of the CON program, and focus on what Dr. Kaminsky and his department see as a dysfunctional system of financial disincentives to good patient care.

Dr. Kaminsky writes that his department generally concurs with the Working Paper's conclusions, among them that "State hospitals are facing increased admissions" because of two interacting factors: the "decreases in length of stay and restrictions on admissions" to both acute general units and private psychiatric hospitals as a result of managed care, and the pressure to reduce length of stay in the general hospital setting, which have intensified over the past two years with the institution of HSCRC's charge-per-case rate-setting system.

Dr. Kaminsky and his department also share Staff's concern over the potential impact of the provisions of HB 994 that permit both State hospitals and those in the four

[14] Dr. Kaminsky's letter notes that Johns Hopkins Hospital planned to submit separate comments "consistent" with his Department's views; to date these comments have not been received, but the Hospital can also submit comments in response to this document, particularly with respect to Staff's recommendation for Commission action.

[15] As shown in Table 2 of the Working Paper, Johns Hopkins' service consists of 15 beds dedicated to children, and 88 adult beds. The University of Maryland Medical Center is the second largest service, at 60 beds; this total includes 12 child beds, and 48 adult beds, of which 20 are designated for geriatric patients. The next largest acute hospital service is that of Washington Adventist Hospital in Takoma Park, with 40 adult beds.

most populous jurisdictions – Baltimore, Montgomery, and Prince George's Counties and Baltimore City – to close if they give written notice to the Commission 45 days beforehand, and hold a public hearing within 30 days of providing that notice. As other commenters (notably, LifeBridge and MedStar) also observed, the short notice and the absence of opportunity for public response and for Staff to evaluate the impact of the closure on its community's continued access to psychiatric care (through the analysis performed during a CON exemption review, which requires action by the Commission within the same 45-day time frame) "exacerbate[s] an already strained system."

In arguing that the system is "broken," Dr. Kaminsky describes a recurring situation at Johns Hopkins, in which patients languish in the emergency department for 24 to 72 hours awaiting placement in another facility because the Hopkins unit's beds are full – while, according to the utilization and occupancy figures presented in the Working Paper – only 63% of other acute general and about 50% of private hospital beds are occupied. Clearly, the system has sufficient bed capacity: CON review has not resulted in a scarcity of inpatient psychiatry beds, so why are patients waiting in emergency rooms for placement? Dr. Kaminsky suggests that the following three data analyses, undertaken by the Commission (in conjunction, where indicated, with the Mental Hygiene Administration and the Medicaid program) could confirm what his department believes is the answer to that question:

- A definitive survey to determine the number of inpatient beds in all three hospitals sectors that are actually budgeted and staffed for operation – available for patient care, not just on paper;

- An analysis of the 44% of State hospitals patients being referred to the acute general hospitals, by emergency room and by psychiatric unit, and of the length of stay needed by patients from each referring hospital, could identify the source of the greatest increases in referrals to the State hospitals; and

- A study done in cooperation with the responsible State health department agencies of the effect of the Medical Assistance "carve-out" of mental health services, to determine "the origin of the increased demand" for inpatient services by understanding where patients in all three hospital sectors received outpatient services, before and after the 1997 creation of the Public Mental Health System.

The Hopkins psychiatry department believes that the "unintended consequence of the Medicaid reform was to disrupt stable outpatient health care patterns among a marginal and fragile severely and persistently mentally ill population" because – although the new system gave these patients far greater choice of participating providers -- it also resulted in "massive closures of grant-supported outpatient clinics that had previously taken care of the sickest populations and that had responsibility to care for the population within a defined geographic area." This disruption of care patterns in turn resulted in relapses of illness in a significant number of patients in the public system – relapses that typically require "3 to 5 years of effort . . . to re-establish stable community residence."

During this period, these patients are "markedly unstable, with frequent psychotic relapses and frequent hospitalizations."

Dr. Kaminsky's letter, turning to the Hopkins unit's own experience and issues, makes two statements intended to initiate a "vigorous public discussion" about the problems facing every provider, payer, and consumer of mental health care in Maryland today. First, the Hopkins department believes that, in their present financial and clinical context, "the general hospital psychiatric units, taken as a whole, have lost their mission." As a result of "the combined pressure of managed care and the HSCRC reimbursement system," the former mission of psychiatry departments in acute general hospitals – crisis intervention and the initiation of psychotherapy – has been downgraded to "crisis stabilization," which can often be accomplished without any improvement to long-term outcome. Managed care has whittled the average length of stay in acute hospital units to the 6.69 days cited in the Working Paper's Table 7, but cannot "create the connections between inpatient, outpatient, and other services that truly affect outcome."[16]

Dr. Kaminsky argues that HSCRC's rate-setting methodology provides a disincentive to general hospitals to take the more difficult cases, because the "resource-utilization predictions" required in order to balance overall lengths of stay within a department's target "cannot be made" about medically complicated psychiatric patients, the way that resource allocations and any needed case-mix intensity adjustments can be made for surgical patients. As a result, the present rate-setting framework has created the perception, and practice, in many general hospital psychiatric units that they need to seek out "a sufficient volume of easy cases," and transfer complex patients, particularly those with significant co-morbidities, to State and private psychiatric hospitals. From there, when their underlying medical conditions require, they are transferred back to the acute care hospitals, and "ping-pong back and forth."

The combined effect of all of these circumstances produces the Hopkins department's second conclusion: that "Maryland does not have a psychiatric health care system," but rather "a system of financial incentives." What a system focused on financial incentives rather than on patient care needs has produced, from the perspective of the largest acute hospital psychiatry department, is a gap-ridden, badly coordinated system of mental health services. The acute hospital units "do not seek to develop specialty expertise and services for difficult psychiatric populations"; the private psychiatric and the State hospitals "play any role that they can"; graduating psychiatry residents steer clear of public psychiatry; and all "are responding to financial incentives and not the needs of patients."

[16] The hospital-specific data on patient days and average length of stay included as appendices to the Working Paper show that Johns Hopkins Hospital's psychiatry unit has consistently maintained the State's highest number of patient days (28,069 in FY 2000; UMMC was second at 15,486, and the closest community hospitals were Prince George's Hospital Center at 7,739 and Sinai with 7,546) and also the longest average length of stay, at 11.59 days in FY 2000 to UMMC's 9.26 days. St. Joseph Hospital is second-highest among acute care hospitals, at 10.53 days, possibly attributable to longer stays related to its eating disorders unit.

Dr. Kaminsky's comments on behalf of the Johns Hopkins psychiatry department return to a theme underlying most of the letters received in response to the Commission's examination of its regulation of inpatient psychiatry through Certificate of Need. The challenges and obstacles to available, accessible inpatient psychiatric care, across all three hospital settings, are not the result of Certificate of Need regulation, but go far beyond questions of bed capacity, to the policies governing the organization and financing of a coordinated and truly comprehensive system of mental health care. The update of the Commission's State Health Plan, "where patient need is the focus," presents an appropriate vehicle to focus the attention of State government – and the public – on these issues.

Comments submitted on behalf of the **Health Services Cost Review Commission** by its Executive Director Robert Murray address, in turn, the "dynamics" of its rate regulation of all payers for inpatient psychiatric services provided at Maryland acute general hospitals, and issues involving its regulation of rates paid by commercial payers for services provided at the private psychiatric hospitals.

The HSCRC's redesigned rate-setting methodologies, including the imposition and monitoring of case-mix adjusted "charge-per-case" targets for acute care hospitals, have established a structure that "allows for rate updates beginning in Fiscal Year 2002 based on a formula that is directly tied" to the national growth in hospital costs. The CPC methodology holds each hospital to a per-case constraint across the full range of inpatient services it offers, but "give[s] hospitals the flexibility to focus control on specific areas of cost and utilization by type of service." HSCRC's comments focus on this aspect of the CPC methodology, the Murray letter notes, because if many acute general hospitals are aggressively planning for discharge almost as soon as a patient is admitted,[17] or seeking out "a sufficient volume of easy cases" to protect their performance against CPC targets, then it is by their choice, and not in response to a Commission directive."

HSCRC's comments also note the work ongoing at the Department of Health and Mental Hygiene, assisted by Cost Review Commission staff, to establish a prospective payment system for Medicaid payments to private psychiatric hospitals; HSCRC currently sets rates only for commercial payers. DHMH intends for the methodology to support this new Medicaid PPS to be completed by December 2001. Having thus brought the Medical Assistance patients into its rate-setting framework, with the goal of relieving the financial pressure on the private psychiatric hospitals resulting from the current TEFRA-mandated system of delayed, retrospective payment accounting, HSCRC states unequivocally that it does not support the inclusion of private psychiatric hospitals within Maryland's Medicare Waiver. Since HSCRC has concluded that extending the Medicare Waiver to these hospitals is "not a viable option for a variety of policy reasons," it appears very unlikely that Medicare reimbursement for patients in this

[17] This statement in the Working Paper was based not only on MHCC's hospital discharge abstract data showing that Statewide average length of stay continues to decline, but also on information presented at numerous meetings between Commission staff and staff of the Mental Hygiene Administration and other State agencies between mid-2000 and the present.

hospital setting will be in a position to improve with increased productivity, as the new PPS system enables Medicaid rates to do.

Summary Table: Options Supported by Comments on Working Paper

Commenter	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Assn of Maryland Hospitals and Health Systems (MHA)	✕					
Howard County Board of Health	*		✕	✕		
Adventist HealthCare/Potomac Ridge Behavioral Health	✕					
Sheppard Pratt Health System	✕					
Taylor Manor Hospital	✕					
Carroll County General Hospital	✕	✕				
LifeBridge Health	✕	✕	✕			
MedStar Health	✕					
Dept of Psychiatry, Johns Hopkins Hospital	*	✕	✕			
HSCRC**						

*Implicit support of continuing CON regulation, since supports one or more CON-related options.

** HSCRC took no position on an alternative to CON regulation of this service.

III. Staff Analysis of Public Comments

In its examination and discussion of the public response to and its own recommendations with respect to the Working Paper's six alternative options, Staff presents them in a slightly different order, considering the widest departures from present practice first.

Option 6: Deregulate Inpatient Psychiatric Services from Certificate of Need Review

No institution that provided comments on the Staff's working paper advocated the deregulation of inpatient psychiatric services, in any of the three hospital settings, from its current Certificate of Need requirement. The consensus among those commenting was clearly that the CON program has not presented an obstacle to establishing adequate bed capacity to serve all areas of the State. What obstacles do exist to access to these services are the result of a variety of factors, including financial disincentives to providing care, as experienced or perceived by inpatient facilities; State budgetary constraints and other legislative decisions; shortages of nurses and other critically-needed health professionals; and the restrictive reimbursement policies imposed by managed behavioral health organizations. The solutions to these problems, Staff believes and the comments concur, lie beyond the authority and scope of the CON program. In the provision of inpatient psychiatric care, arguably more than in any other medical service subject to Commission oversight, changes and challenges felt by one sector will reverberate in the other two, and dislocations in patterns of and payment for outpatient

services – such as those resulting from the transition to the State's public mental health system – have also had an unsettling and largely negative impact.

Because the problems besetting the provision of inpatient psychiatric services in Maryland do not stem from CON regulation, Staff does not recommend removing the CON requirement for to establish new psychiatric facilities, and in some cases new inpatient psychiatric bed capacity.[18] If, through a determined and cooperative effort any of the financial obstacles to providing psychiatric care can be mitigated, controlling service capacity through Certificate of Need will again serve its fundamental purpose, and help to ensure that any growth in bed capacity or new facilities is firmly linked to demonstrated need.

Option 4: Deregulate Inpatient Psychiatric Services from Certificate of Need Review; Create Data Reporting Model

Several commenting institutions noted that having more useful and non-duplicative data on the utilization of inpatient psychiatric services -- with this information made available to all providers and policymakers – would be a positive step. However, most were less than comfortable with the idea of a report card oriented toward consumers, since, as Potomac Ridge observed, "unless the consumer truly understands the nature of behavioral health, [and] understands the difference(s) in patient populations between providers," a report card approach might be misleading.

Responding to a legislative mandate enacted in 1999 as part of a broader statute intended to focus public policy attention on the relationships between health insurers and their providers (and administrators) of behavioral health care, the Maryland Health Care Commission has thoroughly examined the issue of reporting quality measures for these services. Between its initial meeting in late September 1999 and its Final Report to the General Assembly in December 2000, the Commission's Task Force to Develop Performance Quality Measures for Managed Behavioral Health Organizations explored the complex arrangements that exist between medical plans and managed behavioral health organizations. Early in its deliberations, the Task Force realized that its work was further complicated by the "absence of generally accepted measures of behavioral health quality," particularly those measures oriented toward patient outcomes, not simply satisfaction with how services were provided and paid.[19]

The final report of the Task Force, accepted and forwarded to the General Assembly to the Commission, recommended that behavioral health reporting be "integrated into the MHCC's consumer reports for commercial HMOs," that "a variety of descriptive indicators of behavioral health care" be publicly reported in the

[18] As the Working Paper notes, in the annual recalculation of licensed beds for acute general hospitals established by HB 994 in 1999 and implemented first in October 2000, any hospital with an existing psychiatric service may increase (or decrease) the number of beds it has dedicated to that service, within its authorized total beds.

[19] Executive Summary, page i, Final Report of the Task Force, Maryland Health Care Commission, December 15, 2000.

Commission's 2001 reports on HMOs, that commercial HMOs be required to report details of their behavioral health arrangements to the Commission, and that HMOs should be required to survey patient satisfaction in their behavioral health care. In recognizing that "the adoption of outcome measures as indicators of performance quality" was not yet feasible, the Task Force recommended that this be pursued in the future, and that a group similarly constituted should periodically reconvene to review other measures of behavioral health quality as they become available.

The Commission, through its own ongoing work and that of the Task Force, has determined that measuring the quality of behavioral health services is an evolving science, not yet at a stage where it can be fully integrated into the HMO report card, its instruments still in the testing stage. Staff, therefore, believes that any consideration of using consumer education through the reporting of quality measures as a substitute for CON regulation of new inpatient psychiatric bed capacity is extremely premature. This is particularly true in a medical service whose utilization is so aggressively restricted as to embody the very opposite of consumer choice.

Option 5: Deregulate Mental Hygiene Administration Hospitals from Certificate of Need Review

This option received no support among the comments submitted to the Working Paper, among those who chose to address the issue of bed capacity in State psychiatric facilities. Potomac Ridge/Adventist HealthCare asserted that the CON regulation of State facilities was not the significant issue: it is the failure of the State budget to provide sufficient funds to operate more of the public system's available bed capacity that causes such problems as backups in acute hospitals' emergency rooms and the "seasonal and cyclical bed shortages" experienced by the acute and private hospitals.

It is certainly true that the State hospitals are operating at less than two-thirds of their total bed capacity; the downsizing of State hospitals remains the explicit policy of the Mental Hygiene Administration, because it is the intent of the General Assembly. It could be argued, in response to the Adventist position, that the stalling of that downsizing effort and the continuing high census in State facilities is not the cause of problems in the acute and private sectors, but their result. As Dr. Kaminsky points out in the Hopkins psychiatry department's comments, the utilization data presented by the Working Paper illustrates that acute hospital units currently operate at about 63%, and the private facilities at about 50% occupancy. Since the State hospitals were budgeted in the previous fiscal year to operate just over 61% of their available beds, bed capacity – the primary purview of CON regulation – is not causing the problems of this system.

An analysis of the 44% of the patients admitted to State hospitals to determine the general hospital psychiatry units and EDs making most of the referrals, such as Dr. Kaminsky proposes, would be useful for several reasons. This analysis could identify the areas where a general hospital unit may be needed, if one does not exist. It could well identify a pattern in which even a hospital with inpatient psychiatric beds is unwilling to accept a chronically ill or medically complex patient, and makes the closest State facility the placement of first, not last resort. The critical situation facing State hospitals, the

tension between the mandate to downsize and the pressure to accept patients formerly admitted and treated by the other two sectors, has been created by several interrelated factors. What seems clear is that –while the need for inpatient treatment of its population, the most vulnerable, poor, and resistant to treatment should be adequately addressed – the State hospital system cannot, and should not, compensate for the financial disincentives and difficulties facing the acute general and private hospitals.

Thus, Staff believes that removing the CON requirement to establish a new State hospital facility (since HB 994 has already removed the former requirement to obtain Commission action through CON exemption for closure of State facility, regardless of its location) would not be advisable. Keeping all three settings of inpatient psychiatric care under the same basic regulatory framework serves an important purpose, one perhaps more important because of the increased pressure on State facilities' occupancy. Even if funds are budgeted and approved by the legislature to build a new State psychiatric hospital, the currently-required CON review would analyze the need for additional bed capacity where it is proposed, and scrutinize the reasonableness of the proposed costs of construction and operation. CON review in this instance provides a second, expert opinion – which, when public funds are involved, and when the appropriate balance of the inpatient system is part of the analysis – is important to maintain.

Staff also concurs with comments calling for a re-examination and re-establishment of the unique missions of each of the three inpatient settings, and efforts to explore partnerships between the State and private hospitals to divert some of the increased patient load, as proposed by both Sheppard Pratt and Taylor Manor Hospitals. Consideration of such an arrangement is quite timely, since the State's new prospective payment system for private psychiatric hospitals is under active development, and should encourage these facilities to participate. As it is being shaped, with the considerable expertise and experience of HSCRC staff, this system is intended to provide incentives through rate increases for greater efficiencies achieved in patient care, so the facilities and the patients both should benefit.

Option 3: Deregulate Creation of Additional Levels of Inpatient Psychiatric Services from Certificate of Need Review

This option captured the attention and support of most of the commenters, as a means of encouraging – through the incentive of a lesser level of administrative review and approval – the expansion of inpatient bed capacity for children and adolescents across the State. The Working Paper's table of the number of beds in acute general hospitals by State Health Plan-defined category of patient shows that an extremely small percentage of the 658[20] acute care beds across the State: only 27 beds dedicated to children and 7 designated for adolescents. Hospital utilization data in the Commission's Hospital Discharge Abstract show (as Sheppard Pratt observed in its comments with regard to adolescents) that hospitals without designated child or adolescent beds, even some facilities without CON approval for a psychiatric unit, admit patients in those age

[20] The 658-bed figure was for FY 2001; the final Phase 2 report will update Table 2 with the by-service bed totals designated by the general hospitals for FY 2002.

groups with one or more psychiatric DRGs, this practice is neither consistent with their regulatory approval, nor appropriate psychiatric care.[21] Although more child and adolescent beds are available in the private hospitals – each of the four operating facilities have child and adolescent beds, a Statewide total 243 of the 678-bed overall FY 2000 capacity -- the relative scarcity of this resource, and the repeated reports of great difficulty in locating inpatient psychiatry placements for children and adolescents in general hospitals, support any measure to encourage more bed capacity.

The Working Paper presented two procedural alternatives to accomplish the overall purpose of expediting a Commission review of any proposal on the part of an existing hospital to establish a child or adolescent service in addition to its adult program. Both alternatives require changing the State Health Plan's stipulation that for each additional category of care, a separate Certificate of Need approval is needed. This could occur in the context of the upcoming Plan revision and update. Indispensable to the revision of this Plan standard would be the substitution of specific standards for each category of care, which could include a requirement for an on-staff, Board-certified specialist in the age group, particular staff training and staffing ratios, and separate physical space for patient beds and clinical programs for the proposed new service.

The level of review and approval that the new Plan would require, in which Staff would apply the category-specific program and physical space standards, could be either Commission action through an exemption from Certificate of Need review, or a determination issued by Staff, following its evaluation of the proposed new service against the new Plan standards. The key difference between the two paths is that CON exemption requires an action by the Commission, albeit after a 45-day expedited Staff review and recommendation, and a Staff determination does not. The same level of Staff analysis and evaluation would be undertaken in either case.

Since the intensity of the analysis and the time required are essentially the same, Staff believes that this change should require the Commission's action, through CON exemption. This option represents a departure from the State Health Plan in effect since the late 1980s, and an extension of the Commission's historic use of the CON exemption tool. Commission statute does not distinguish between the different levels of psychiatry, in its list of the medical services whose establishment requires Certificate of Need approval; however, the inclusion in that list "subcategories of rehabilitation, psychiatry, comprehensive care, or intermediate care" for which the Plan separately projects need may mean that a statutory change would also be needed.[22] The intent of this option, regardless of the statutory or regulatory adjustments needed to accomplish it, is to preclude the definition of additional categories of psychiatry as a *new* service, but to define them instead as new categories within a facility's existing inpatient psychiatry service. Staff believes that the need to provide an incentive for the creation of more child

[21] As noted above, in its next Working Paper, on child and adolescent inpatient psychiatry, Staff will present data on the extent to which children and adolescents with primary psychiatric DRGs have been admitted to hospitals without designated units.
[22] See §19-123(a)(4)(ii).

and adolescent inpatient psychiatry services should be considered and acted upon by the Commission, but should not require a full, separate CON review.

Option 1: Maintain Existing CON Regulation

Nothing in its detailed consideration of the supply, utilization, reimbursement, or issues and problems of inpatient psychiatric services in Maryland has caused Staff to consider that any change should be proposed in the overall framework of CON regulation of this service. The consensus among the commenting institutions is clear in its agreement with that position. In a segment of health care that faces so many challenges, and in which the balance between its three distinct settings is so important, taking an action that could well further destabilize the situation without a compelling reason to do so should not be an option.

However clear the consensus is among the commenting providers that CON regulation "is not the problem," and should continue, there is some disagreement about how – and how equally -- some key provisions of HB 994 apply to each of three separate hospital settings. The Working Paper questioned the applicability of the hospital closure rules to private psychiatric hospitals, since several other provisions of HB 994, meant to be interrelated, apply only to acute general hospitals – "hospitals licensed as general hospitals" under the licensing statute at §19-307. Taylor Manor Hospital argues that the closure rules (and statutory provisions relating to mergers of facilities) are intended to apply to private hospitals, since "there does not seem to be a reason to differentiate" between the two kinds of hospitals.

Staff respectfully disagrees, since the licensing statute itself assigns a different category to psychiatric beds in an acute hospital, which must maintain an emergency department and a full range of staff and clinical capability to treat somatic as well as psychiatric illnesses, and the "special" designation of the private, freestanding psychiatric hospitals. Another difference between these two inpatient settings is their status with respect to HSCRC's rate-setting authority and to the Medicare Waiver: HSCRC sets rates for all payers of acute general hospital services, since they are included in the Waiver, but to date, until the new PPS is implemented, only sets commercial payer rates for the private hospitals, which are not under the Waiver.

Staff believes that some ambiguity exists in the relevant provisions of HB 994, with respect to the drafting of the text of these provisions, and in their relationship to each other. For example, because the annual recalculation and relicensing of bed capacity in "a hospital classified as a general hospital"[23] meant that these facilities could no longer create "waiver" beds[24] – but the new statute also conferred upon them the ability, at §19-123(i), to relocate beds between member facilities of merged asset systems. All of these provisions were logically related to each other, and arguably, were intended to apply only to acute general hospitals. The ambiguity of interpretation lies in

[23] At §19-307.2(a).

[24] Commission regulations explicitly interpreted this provision as applying only to acute general hospitals, and still consider hospitals with "special" licenses eligible for waiver or "creep" beds.

the fact that the qualifying adjective "general" is not always used; the Commission's regulations clarified the intent as much as possible in its implementing regulations, but some questions remain, largely because of the different licensure categories involved.

Another provision of HB 994 whose interpretation was questioned by some commenters involves the ability of merged asset hospital systems to reconfigure bed capacity between their members, and thereby begin a "new" service through that relocation of system beds and services. MedStar warns that "giving merged asset systems the ability to relocate psychiatric services across jurisdictions would set a dangerous precedent," and result in "dramatic redistribution of beds with minimum public input." In fact, under current statute and the State Health Plan, merged systems already have the ability to seek CON exemption to reconfigure inpatient psychiatric services within the regions established by the Plan: unlike other medical services provided at acute general hospitals, psychiatry is planned for on a regional basis, not on a county level.[25]

Staff believes that the lack of agreement on the interpretation and applicability of certain key provisions of law, especially those related to the ability of hospitals in certain jurisdictions – and all State hospitals -- to close 45 days after notifying the Commission and holding a public hearing, argues that further clarification may be needed, whether through regulatory or statutory changes. Clarification, and perhaps some further refinement of these provisions is arguably more important in inpatient psychiatry than in any other hospital service, because of the impact that facility or service closures would have on continued access to inpatient psychiatric care, in a system already significantly challenged by reimbursement and staffing issues.

Option 2: Expand Certificate of Need Program Regulation

The discussion and concerns described under Option 1, about the applicability of existing Certificate of Need statute to proposed closures of inpatient psychiatric beds within general hospitals and to the "special"-licensed private and State hospitals, led to the Working Paper's Option 2, which would re-impose the requirement to obtain Commission action through a CON exemption on hospitals in jurisdictions with three or more hospitals.

It would be difficult to argue with the intent of the provision of HB 994 that made the closure of a hospital "or part of a hospital" in multiple-hospital jurisdictions possible with relatively short public notice and a public hearing held after the final decision had already been made, in jurisdictions with three or more hospitals. Although the first round of HB 994's "140% rule" calculations have largely extracted so-called paper beds from

[25] As noted in the Working Paper, the Commission granted a CON exemption to LifeBridge Health in June 2000, to reconfigure the system's psychiatry service by allocating 12 of its adult psychiatry beds at Sinai Hospital in Baltimore City to Northwest Hospital in Baltimore County. The unit at Northwest opened officially on August 1, 2001, compromised of beds designated from the existing acute bed complement on Northwest's FY 2002 license. Since the State Health Plan of the mid-1980s implemented law giving merged systems significant procedural advantages within Certificate of Need review, the Plan has defined the services provided by merged systems as belonging to the system, and as not constituting a "new health care service" if reconfigured among system members.

the acute hospitals, the view that the system still harbors excess and that more hospitals may (and perhaps should) close retains its force. The urge to make exit from the market easy for acute general hospitals in large and populous subdivisions, and for State hospitals since their operation so totally depends on budget imperatives, was completely rational and well-founded.

However, for inpatient psychiatric facilities and services, with the constellation of other issues they face, this provision could have some serious consequences.[26] When HB 994 was conceived and enacted, the State hospitals' mandate to downsize had not yet been clouded by burgeoning admissions. If the ability to close without any Commission oversight or review applies to private hospitals, which can be argued, then three of the five hospitals are located in Baltimore and Montgomery Counties, and so fall under the "three or more" rule. And, if many general hospitals are seeking less complex, quickly discharged patients and, as has been reported, pressuring their psychiatry departments to stabilize patients and move them elsewhere, then the decisions to get out of the business altogether may be a logical one.

Staff believes that re-imposing the requirement for a Commission action after an expedited review for a proposed closure of inpatient psychiatry (or for any medical service to which continued access may become a public health problem) may be accomplished without changing the provisions of HB 994 as they relate to entire facilities. A means of accomplishing this is proposed in the recommendation for Commission action that follows. In making this circumscribed proposal to refine HB 994's closure provisions when reasonable access to a particular service may be compromised, Staff concurs with MedStar Health, that "existing CON regulations provide sufficient oversight, when they are applied equally to all inpatient psychiatric settings, whether they are located in acute hospitals, freestanding private hospitals, or in State-operated facilities."

IV. Staff Recommendation

Based on both the research and analysis performed during the preparation of its working paper *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Inpatient Psychiatric Services*, and its analysis of the public comment received in response to that document, Staff recommends that the Commission continue to regulate the establishment of psychiatric beds and facilities by means of the Certificate of Need process, but also proposes several changes and clarifications to that statutory and regulatory authority.

Essentially, Staff proposes that the Commission's recommendation to the General Assembly on the continuation of Certificate of Need review, with regard to inpatient

[26] Another alternative strategy for stressed general hospital psychiatry units, presented by HB 994's annual hospital bed relicensure program and existing Commission statute permitting hospitals to reallocate beds among their existing services, is to reduce the number of psychiatric beds operated. This raises the question of critical mass, of how many beds and how much staff is needed to operate a viable, good quality program – the same kind of question raised by psychiatric admissions to hospitals without designated units.

psychiatric services, include Options 1, 2, and 3, essentially as they were characterized in the Working Paper. The recommendation would include the following elements:

1. **The Commission recommends that Maryland continue to regulate the establishment of inpatient psychiatric facilities, services, and bed capacity through the Certificate of Need review process.**

2. **The Commission recommends that an additional provision be enacted into existing statute governing the ability of hospitals in jurisdictions with three or more hospitals to close, to impose the requirement of Commission review and action through CON exemption if a proposed closure of an individual medical service means that the number of hospitals providing that service in the jurisdiction would fall below a minimum access standard to be established in the State Health Plan.**

Staff proposes that the Commission recommend to the General Assembly that language be enacted to refine and further clarify provisions of HB 994 with regard to closures of inpatient psychiatry or any other individual medical services in jurisdictions with three or more hospitals. This additional provision would not affect the current statute with regard to the closure of entire facilities in these jurisdictions. However, Staff believes that HB 994's overall responsiveness and flexibility would be strengthened by adding to its existing provisions a requirement for Commission review and action if the proposed closure of an identified medical service – even in jurisdictions with three or more hospitals – would cause the number of facilities *providing a particular medical service* in the jurisdiction to fall below minimum access criteria that would be established in the State Health Plan.

This provision should apply to all categories of hospital, in the interest of applying the existing CON rules equally across all inpatient psychiatry settings. Only in inpatient psychiatry services (and to a lesser extent, in chronic hospital and inpatient rehabilitation) do "special hospitals" and State hospitals provide such a significant degree of inpatient hospital care. Because all hospitals since 1985 have had the ability to seek an exemption from CON to close – not full CON review and approval – the additional provision would not impose a greater administrative burden. In practice, this clarification of HB 994 is likely to apply almost entirely to proposals to close inpatient psychiatric facilities or services, as is Staff's intent. And, in practice, neither the time expended nor the final outcome of the proposal to close a hospital's service or a facility is likely to change. What would be gained is, as MedStar's comments observed, is time to analyze the impact of the closure on access to these services in the affected area, as well as "timely notification, and the orderly transition of services."

3. **The Commission will change the State Health Plan's current requirement for a separate Certificate of Need approval for each additional category of inpatient psychiatric service, to require an exemption from CON and to establish specific standards to met for each additional category. A statutory change may be needed, in order to clarify that, for an existing adult psychiatry service in a general hospital, the addition of child or adolescent psychiatry does not constitute a "new" medical service, requiring CON approval.**

Finally, as noted above, Staff proposes to implement Option 3, by changing the present State Health Plan's requirement that an existing psychiatric facility or general hospital with an existing inpatient service obtain and additional, separate Certificate of Need approval for each category of psychiatric care. Staff will develop specific Plan standards to guide the review and approval of the proposed additional service, which will be included in the update and revision of the Plan, and thereby receive extensive additional public comment as part of the regulatory review process. Staff proposes to work with counsel to determine whether any clarification to statute is needed in order to consider this expansion of an existing medical service as an exemption from CON, acted upon by the Commission, following a staff review and recommendation.